

MEDICAL RECORDS TECHNICIAN 2

KIND OF WORK

Technical medical records leadwork.

NATURE AND PURPOSE

Under general direction, supervises and coordinates the medical records function in a large state hospital or institution. Acts as leadworker; develops policies, procedures, and recordkeeping systems to meet requirements and standards of regulatory, licensing, and accrediting agencies; develops and/or conducts in-service training for other staff; performs related work as required. Problem-solving involves thinking which is guided and circumscribed by substantially diversified procedures and specialized standards. The incumbent is presented with differing situations requiring search for solution within an area of learned things.

This class is broader in scope and breadth of responsibility than the Medical Records Technician 1 class. The Medical Records Technician 2 has overall accountability for a large and complex records department at a state hospital or institution, while a Medical Records Technician 1 has responsibility for maintenance of medical records for either a small limited service health unit or institution or for a group of similar patients within a large institution.

EXAMPLES OF WORK (A position may not include all the work examples given, nor does the list include all that may be assigned.)

Direct work of other medical records staff, which may include other medical records professionals, in order to insure that medical records services and activities address the needs of the hospital staff (patient records are accurate, complete, and easily accessed) as well as standards and requirements of regulatory, licensing, and accrediting agencies by developing policies, procedures, systems, and forms for computer and hard copy medical record maintenance and storage, vital statistic recordkeeping and reporting, and release of medical information; training or directing training of other staff in these policies, systems, and procedures; establishing work priorities, schedules, and assignments for other personnel; and counseling and/or evaluating the work of other personnel.

Records and summarizes medical information including, but not limited to, doctor's diagnosis, patient census data, patient treatment information, admissions, discharges, and deaths, to provide information to hospital staff and regulatory agencies by gathering and assembling information and medical data from treatment logs and admissions records, individual records and rough notes; requesting additional information of patients and families, as necessary; coding doctor's diagnoses of disease by reference

to standard diagnostic manuals; recording coded diagnoses in standard index; performing basic mathematical functions (addition, subtraction, computing averages) to obtain aggregate data; preparing graphic presentation of such data (e.g., charts, tables, graphs); and developing and maintaining a filing system for prompt information retrieval.

Audits individual patient files for complete and accurate information (e.g., documentation of diagnoses and continued stay, current Medicare certification, basic medical history data, etc.) to insure that patient records are accurate and complete and properly coded and filed by conducting periodic reviews of all patient files, assembling patient files upon admission, comparing contents of patient files with established government and regulatory agency standards of record maintenance, requesting additional or missing information from doctors, patients, and patient's families verbally or by form letter, and/or informing the administration of those doctors who are excessively delinquent in writing and signing reports.

Reviews and approves court orders and telephone or written requests for release of patient information to insure that they are authorized by writing policies and procedures to guide proper release of patient information and supervising and coordinating the collection and dissemination of such information.

Prepares periodic reports on hospital activity for administrative personnel or regulatory agencies by interpreting rules and regulations of regulatory agencies, identifying information needs of administrative personnel, delegating tasks to subordinates for completion, collecting data for medical records or indexes, summarizing data using simple mathematics, and preparing and distributing reports to appropriate places and persons.

Types, transcribes dictation and data and performs various other clerical duties, as assigned, to ensure that the department's work is completed accurately and efficiently.

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED

Knowledge of:

Department and regulatory agency guidelines regarding medical records maintenance sufficient to establish and train subordinate employees in recordkeeping procedures and policies, to approve release of information, and to develop or design and prepare periodic reports.

Medical terminology sufficient to encode, classify and/or transcribe doctor's diagnoses, recommended treatment and notes.

Mathematics sufficient to add, subtract, divide and calculate averages.

Skill in:

Typing sufficient to complete a variety of reports, letters, and data summaries.

Ability to:

Make decisions by applying precedence and regulations to various situations.

Encode data using standard medical coding systems.

Establish and maintain pertinent policies and effective working relationships with other employees and the public.

Maintain well-organized and detailed records upon which periodic reports are based.

Efficiently and fairly direct and distribute work to others.

LEGAL OR LICENSURE REQUIREMENTS (These must be met by all employees prior to attaining permanent status in the class.)

Certification as a Registered Health Information Technician.

Est.: 03/87
Rev.: 05/03, 9/18
Ckd.: 05/03

T.C.:
Former Title(s):